



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CY-FAIR CHIROPRACTIC ASSOC

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-17-1069-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

DECEMBER 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted.

Amount in Dispute: \$1,936.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that a large number of the charges listed on the DWC060 have been paid at fee schedule...There has not been a DWC73 form submitted on this 5/24/16 DOS date. The submission of the form is required for reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	CPT Code 99212-25 Office Visit	\$75.00	\$0.00
	CPT Code 98940 Chiropractic Manipulation, Spinal 1-2 regions	\$55.00	\$0.00
	CPT Code 97140-59-GP Manual Therapy Techniques	\$55.00	\$0.00
	CPT Code 97110-GP-59 Therapeutic Procedures	\$55.00	\$0.00
	CPT Code 97530-GP-59 Therapeutic Activities	\$65.00	\$0.00
	CPT Code 97112-GP-59 Therapeutic Procedure	\$55.00	\$0.00
May 24, 2016	CPT Code 99080-73 Work Status Report	\$20.00	\$0.00
May 31, 2016	CPT Code 98943-51 Chiropractic Manipulation, Extraspinal 1 or more regions	\$58.00	\$0.00
TOTAL		\$1,936.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 16-Documetnation does not support billed services.
 - 16-DWC-73 form must be submitted in order for reimbursement to be made. No DWC73 firm received by billing or submitted to the carrier.

Issues

1. Does the documentation support billing CPT code 99080-73?
2. Is the requestor entitled to additional reimbursement?

Findings

1. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the submitted documentation finds that the requestor did not submit a copy of the work status report to support billing. As a result, reimbursement is not recommended.

2. The Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 - (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
 - (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and

shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77065, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Houston, Texas”.

Using the above formula, the Division finds the following:

Dates of Service	CPT Codes	Medicare Participating Amount	MAR	Amount Paid	Check No.	Amount Due
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	99212-25	\$44.09	\$69.97	\$69.97/ea	321823 322043 322146	\$0.00
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	98940	\$28.99	\$46.01	\$46.01/ea	321823 322043 322146	\$0.00
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	97140	\$30.44	\$48.31	\$48.31/ea	321823 322043 322146	\$0.00
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	97110	\$32.95	\$52.29	\$52.29/ea	321823 322043 322146	\$0.00
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	97530	\$35.49	\$56.32	\$56.32/ea	321823 322043 322146	\$0.00
May 10, 2016 May 13, 2016 May 16, 2016 May 24, 2016 May 31, 2016	97112	\$34.39	\$54.58	\$54.58/ea	321823 322043 322146	\$0.00
May 31, 2016	98943	Not priced by Medicare	F&R	\$44.26		\$0.00

Because CPT code 98943 is not priced by Medicare the division refers to 28 Texas Administrative Code §134.203(f) which states, “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection

§134.1(f) which states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The requestor is seeking \$58.00 for CPT code 98943. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.” A review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of \$58.00 for CPT code 98943 would be a fair and reasonable rate of reimbursement. As a result reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	1/26/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.